A6

Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES

COUNTY-SPONSORED GME PROGRAM HEALTH CLEARANCE INSTRUCTIONS

Welcome to Los Angeles County, Department of Health Services (DHS). As a condition of employment/assignment with DHS, you are required to undergo a pre-placement health clearance prior to beginning your work assignment. You must successfully complete the Human Resources in-processing and criminal background check prior to beginning the EHS health clearance process.

This packet includes health screening forms and questionnaires that should be completed prior to your visit to EHS for your health clearance. The completed forms should be presented to EHS on the day of your appointment/visit. Please bring the following forms to EHS at your appointment/visit:

- ☐ **A** **Workforce Member Pre-Placement Health Evaluation** – Must be completed by a physician or licensed health care professional along with Form C. (Your physical exam is not to be self-administered)
- ☐ **B** **Tuberculosis History and Evidence of Immunity** – This form is used as a template to assist with mandated health requirements. **(DO NOT COMPLETE)**
- ☐ **C** **General Pre-placement Medical Questionnaire** – Must be completed in full along with Form A prior to EHS visit
- ☐ **K** **Declination Form** – Must be completed if declining non-mandatory vaccinations
- ☐ **P** **ATD Respirator Medical Evaluation** Questionnaire - Must complete pages 1-2 prior to EHS visit)
- ☐ **T4** **Notice of Privacy Practices**– Must be signed prior to EHS visit

Bringing the following documents with you to your EHS appointment, can also help expedite the processing for an EHS health clearance:

1. **Tuberculosis (TB) Test Record** *(a copy of any **one** of the following)*:

   Completed within the last 12 months

   - ☐ 2 negative Tuberculin Skin Test (TST) records documented in millimeters (This is a two-step TST) **OR**
   - ☐ 1 negative TST record documented in millimeters **OR**
   - ☐ 1 negative single interferon gamma release assay (IGRA) **OR**

   For a positive TB result, submit a Chest X-Ray Report within the last 12 months

   - ☐ 1 positive TST record documented in millimeters with a Chest X-Ray Report **OR**
   - ☐ 1 positive IGRA record with a Chest X-Ray Report

2. **Immunizations Record** and/or Titers to the following:

☐ Measles	☐ Varicella	☐ Acellular Pertussis
☐ Mumps	☐ Tetanus	☐ Influenza
☐ Rubella	☐ Diptheria	☐ Hepatitis B

During your office visit at EHS, the following will be performed:

- A two-step TST will be conducted if you cannot provide documentation of 2 negative TST records within the previous 12 months. This may require a total of 3 office visits.
- A TST will be conducted if you can only provide documentation of 1 negative TST record within the previous 12 months. This may require a total of 2 office visits.
- If you have been documented with a positive TST or positive IGRA result, you will be required to have a baseline chest x-ray prior to work assignment **OR** provide written documentation of a normal chest x-ray taken no more than 12 months prior to work assignment.
- EHS will assess the immunization documents you provide to determine if you meet evidence of immunity to vaccine-preventable diseases as a requirement for your work assignment.

☐ **APPOINTMENT IS SCHEDULED ON _____ AT _____ AM / PM.**

☐ **NEED TO SCHEDULE AN APPOINTMENT, PLEASE CALL _____.**

☐ **NO APPOINTMENT NEEDED, PLEASE WALK IN DURING THE FOLLOWING OFFICE HOURS:**

DAY	TIME	LOCATION
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		

If you need an accommodation or have work restrictions, you will need to bring in specific orders written by your physician. These cases will be referred to our Return-To-Work Unit for an interactive meeting and an effective work assignment.

Los Angeles County Department of Health Services welcomes you. We want to ensure you have a positive experience during your training with the County. In order to begin your program as scheduled, you need to complete the Human Resources in-processing prior to beginning the EHS health clearance process. Both of these processes need to be completed prior to beginning your assignment. Please contact your GME office or the facility EHS office for further assistance.

Sincerely,

DHS EMPLOYEE HEALTH SERVICES

A

Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES
PRE-PLACEMENT HEALTH EVALUATION

☞ General Information on Page 2

FOR COUNTY DHS EMPLOYEE

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	EMPLOYEE NO.
JOB CLASSIFICATION	ITEM NO.	DHS FACILITY	
DEPT/DIVISION	WORK AREA/UNIT	SHIFT	P/L
E-MAIL ADDRESS	WORK PHONE	CELL/PAGER NO	SUPERVISOR NAME

SPECIALTY EXAM: ☐ Asbestos ☐ Anti-Neoplastic ☐ DOT ☐ Hearing ☒ Color Vision ☐ RFT ☐ HazMat ☐ High Hazard Procedures ☐ Other: _____

ALLERGIES:

Vital Signs			Vision Screening	No Correction	With Correction
HT: ft in	WT: lbs.	BMI:	Right	20/	20/
B/P:	Pulse:		Left	20/	20/
Color Vision Screening: / ☐ NA			Both	20/	20/

Hearing ☒ NA	Audiometer							
	250	500	1000	2000	3000	4000	6000	8000
Right								
Left								

Nurse Signature:_____ Print Name: _____ Date:_____

PHYSICAL EVALUATION			DESCRIPTION OF ABNORMAL FINDINGS
Check each item in the appropriate column.	NORMAL	ABNORMAL	
General	☐	☐	
HEENT	☐	☐	
Lungs	☐	☐	
Heart	☐	☐	
Abdomen/Viscera	☐	☐	
Back/Spine	☐	☐	
Upper Extremities	☐	☐	
Lower Extremities	☐	☐	
Skin	☐	☐	
Neurologic	☐	☐	
Psychologic	☐	☐	

REMARKS:_____

Recommendation:
☐ Pass ☐ Restricted ☐ Fail

Reasons for categories other than Pass: _____

Physician or Licensed Health Care Professional Signature	Print Name	License No.	Date
Facility Name		Phone No.	

A

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	EMPLOYEE NO.:

DHS-EHS STAFF ONLY

MANDATORY FIELD

☐ Pass ☐ Restricted_____ ☐ Fail ☐ Deferred_____

DHS-Provider Signature	Print Name	Date

GENERAL INFORMATION

All potential County employees must satisfactorily complete a health evaluation conducted by Employee Health Services (EHS) or designated facility prior to hire or assignment to determine if the potential employee meets the physical and mental job-related standards established for the prospective job classification/assignment.

If the prospective employee is a minor (person under 18 years of age), consent is required from the minor's parent or legal responsible person prior to obtaining health information or conducting health evaluation or services on the minor unless the minor can consent to such services on his/her own behalf or can document he/she is an emancipated minor.

Pre-placement health evaluation is performed to ascertain medical fitness for duty, document the absence of and/or immunity to certain infectious diseases, and to establish a baseline for those who require ongoing medical surveillance. This evaluation may include respirator fit testing and respirator use. An annual evaluation will be required for returning retirees and reinstatements that have a break in service of one (1) year. All others will be required to undergo a pre-placement health evaluation prior to being rehired. Employees requiring an accommodation must be referred to DHS Risk Management, Return-to-Work for review of needs and to initiate the interactive process for a reasonable accommodation. If the candidate does not timely complete the pre-employment health evaluation process, he/she will be considered to have failed the evaluation.

Health evaluation/screening will be provided to County workforce members and volunteers at no charge. Non-County workforce members and students must obtain medical screenings from their physician or licensed healthcare provider. Health screening for contract staff will be provided in accordance with the terms of the contract. Fees and costs for services at DHS-EHS shall be billed to the school/contract agency as appropriate.

No employee will be allowed to work at a County medical facility without appropriate documentation of health clearance. Employees who provide administrative support services (e.g., DHS Human Resources or Contracts & Grants staff) at a health care facility and require access to patient care areas to perform their job responsibilities are required to adhere to the facility infection control requirements including obtaining initial and annual health screenings and immunizations.

Employees evidencing symptoms of infectious diseases may be medically screened by EHS prior to providing patient care or performing work duties. Employees determined to have infectious potential shall be denied or removed from patient contact and work duties as deemed necessary to protect the safety of patients and workforce members.

DHS-EHS staff shall verify/review documentation(s) and record completion of this form for workforce member. This form and its attachment(s), if any, such as health records shall be filed in workforce member's EHS health file. All workforce member EHS health records are confidential in accordance with federal, state and regulatory requirements.

DHS-EHS will obtain the workforce member's written authorization before using or disclosing medical information, include to self, unless the disclosure is required by State or Federal law such as to a public health authority or governmental regulatory agency.

Workforce members have the right to access their medical records and obtain a copy, thereof, within fifteen (15) days after the request.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. 29 C.F.R. Part 1635

B

Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES
TUBERCULOSIS HISTORY AND EVIDENCE OF IMMUNITY

See General Instructions on Page 3

FOR COUNTY DHS EMPLOYEE

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	EMPLOYEE NO.
JOB CLASSIFICATION	ITEM NO.	DHS FACILITY	
DEPT/DIVISION	WORK AREA/UNIT	SHIFT	P/L
E-MAIL ADDRESS	WORK PHONE	CELL/PAGER NO	SUPERVISOR NAME

FOR COMPLETION BY EMPLOYEE HEALTH STAFF

TUBERCULOSIS DOCUMENTATION HISTORY

A

TUBERCULIN SKIN TEST RECORD
0.1 ml of 5 tuberculin units (TU) purified protein derivative (PPD) antigen intradermal

DATED PLACED	STEP	MANUFACTURER	LOT #	EXP	SITE	*ADM BY (INITIALS)	DATE READ	*READ BY (INITIALS)	RESULT	STATUS (Indicate: Reactor / Non-Reactor / Converter)
	1st									
	2nd									

If either result is positive, send for CXR and complete Section C below.

OR

B	Negative IGRA (<12 months)	Date:	Results_____	☐ LA County ☐ Outside Document	STATUS

If CXR is positive for TB, DO NOT CLEAR for hire/assignment.
Refer Workforce Member for immediate medical care.

C	Positive TST	Date:	Results _____mm	☐ LA County ☐ Outside Document	STATUS
	CXR (<12 months)	Date:	Results_____	☐ LA County ☐ Outside Document	

OR

D	Positive IGRA	Date:	Results_____	☐ LA County ☐ Outside Document	STATUS
	CXR (<12 months)	Date:	Results_____	☐ LA County ☐ Outside Document	

OR

E	History of Active TB with Treatment	Date:	_____months with_____	☐ Outside Document	STATUS
	CXR (<12 months)	Date:	Results_____	☐ Outside Document	

OR

F	History of LTBI Treatment	Date:	_____months with_____	☐ Outside Document	STATUS
	CXR (<12 months)	Date:	Results_____	☐ Outside Document	

CONTINUE ON NEXT PAGE

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	EMPLOYEE NO.

G — IMMUNIZATION DOCUMENTATION HISTORY

	Date	Titer	If not immune give Vaccination x 2, unless Rubella x 1	Date	Vaccine		If WFM declines, WFM must fill out Form K
Measles		☐ Immune ☐ Non-Immune ☐ Equivocal ☐ Laboratory confirm of disease	OR			OR	☐ **May be restricted from patient care areas**
Mumps		☐ Immune ☐ Non-Immune ☐ Equivocal ☐ Laboratory confirm of disease	OR			OR	☐ **May be restricted from patient care areas**
Rubella		☐ Immune ☐ Non-Immune ☐ Equivocal ☐ Laboratory confirm of disease	OR			OR	☐ **May be restricted from patient care areas**
Varicella		☐ Immune ☐ Non-Immune ☐ Equivocal ☐ Laboratory confirm of disease	OR			OR	☐ **May be restricted from patient care areas**

AND

H

Vaccination	Date Received		WFM Declined
Tetanus-diphtheria (Td) Every 10 years		☐ Verbal ☐ Document	☐
Acellular Pertussis (Tdap) X 1		☐ Verbal ☐ Document	☐

AND

I

Vaccination (MANDATORY for WFM who have potential to be exposed to blood or body fluid)	Date Received	Immunity	WFM Declined
Hepatitis B (HBsAb)		☐ Reactive ☐ Non reactive	☐

AND

J

Vaccination (VOLUNTARY)	Date Received	Location Received		WFM Declined
Seasonal Influenza (Annually)			☐ Verbal ☐ Document	☐

ATTACH SUPPORTING DOCUMENTATION(S) WITH THIS FORM INCLUDING ANY DECLINATION (FORM K)

DHS-EHS STAFF ONLY

K	Fit Test (Forms N and O or P)	Date:	☐ **Pass**	☐ **Fail**	☐ **N/A**
L	Pre-Placement Health Evaluation (Form A)	Date:	☐ **Pass**	☐ **Restricted**	☐ **Fail**
M	FINAL RESOLUTION – EHS Health Clearance	Date:	☐ **Pass**	☐ **Restricted**	☐ **Fail**

Completion of this form:	**Reviewed By (Print):**	**Signature:**	**Date:**

GENERAL INSTRUCTION ON NEXT PAGE

GENERAL INSTRUCTIONS

SECTION	
TUBERCULOSIS DOCUMENTATION HISTORY **ALL WORKFORCE MEMBER (WFM) SHALL BE SCREENED FOR TB UPON HIRE/ASSIGNMENT**	
A	WFM shall receive a baseline TB screening using two-step Tuberculin Skin Test (TST). Step 1: Administer TST test, with reading in seven days. Step 2: After Step 1 reading is negative, administer TST test, with reading within 48-72 hours. If both readings are negative, WFM is cleared to work. WFM shall receive either TST or interferon gamma release assay (IGRA) and symptom screening annually. a. Documentation of negative TST within 12 months prior to placement will be accepted. WFM shall receive a one-step TST with reading within 48-72 hours. If result is negative, WFM is cleared to work; b. Documentation of negative two-step TST within 12 months prior to placement will be accepted. WFM is cleared to work. If TST is positive, record results and continue to Section C.
B	WFM shall receive a baseline TB screening using a single IGRA. If negative result, WFM is cleared to work. WFM shall receive either TST or IGRA and symptom screening annually. a. Documentation of negative IGRA within 12 months will be accepted. WFM is cleared to work. If IGRA is positive, record results and continue to Section D.
TST POSITIVE RESULTS **If CHEST X-RAY IS POSITIVE, DO NOT CLEAR FOR HIRE/ASSIGNMENT, AND** **REFER WORKFORCE MEMBER FOR IMMEDIATE MEDICAL CARE**	
C	If TST is positive during testing in Section A or C above, send for a chest x-ray (CXR). If CXR is negative, WFM is cleared to work. Documentation of negative CXR within 12 months prior to placement will be accepted for clearance to work. WFM shall be symptom screened for TB annually.
D	If IGRA is positive during testing in Section D above, send for a CXR. If CXR is negative, WMF is cleared to work. Documentation of negative CXR within 12 months prior to placement will be accepted for clearance to work. WFM shall be symptom screened for TB annually.
E	If WFM have a documented history of active TB, send for a CXR. If CXR is negative, WFM is cleared to work. Documentation of negative CXR within 12 months prior to placement will be accepted for clearance to work. If documentation is supported, WFM is cleared to work. WFM shall be symptom screened for TB annually. Record documentation result in this section.
F	If WFM have a documented history of latent tuberculosis infection (LTBI) treatment, send for a CXR. If CXR is negative, WFM is cleared to work. Documentation of negative CXR within 12 months prior to placement will be accepted for clearance to work. If documentation is supported, WFM is cleared to work. WFM shall be symptom screened for TB annually. Record documentation result in this section.
IMMUNIZATION DOCUMENTATION HISTORY Documentation of immunization or adequate titers will be accepted. If WFM is not immune against communicable diseases as listed in this section, WFM shall be immunized (unless medically contraindicated). WFM who declines the vaccination(s) must sign the mandatory declination form. WFM who declines the vaccination(s) may be restricted from patient care areas of the hospital or facility. If WFM is non-immune or decides at a later date to accept the vaccination, DHS or WFM contract agency will make the vaccination available.	
G	Documentation of laboratory evidence of immunity or laboratory confirmation of disease will be accepted **OR** documentation of two doses (live measles, mumps and varicella) and one dose of live rubella virus vaccine. Measles vaccine shall be administered no earlier than one month (minimum 28 days) after the first dose. Mumps second dose vaccine varies depending on state or local requirements. Varicella doses shall be at least 4 week between doses for WFM. If Equivocal, WFM needs either vaccination or re-draw with positive titer.
H	**Td** – After primary vaccination, Td booster is recommended every 10 years. If unvaccinated WFM, primary vaccination consists of 3 doses of Td; 4-6 weeks should separate the first and second doses; the third dose should be administered 6-12 months after the second dose. **Tdap** should replace a one time dose of Td for WFM aged 19 though 64 years who have not received a dose of Tdap previously. An interval as short as 2 years or less from the last dose of Td is recommended for the Tdap dose.
I	All WFM who have occupational exposure to blood or other potentially infectious materials shall have a documented post vaccination antibody to Hepatitis B surface antigen HBsAb (anti-HBs). Hepatitis B vaccine series is available to WFM. Non-responders should be considered susceptible to HBV and should be counseled regarding precautions to prevent HBV infection and the need to obtain HBIG prophylaxis for any known or probable parenteral exposure to HBsAg positive blood.
J	Seasonal influenza is offered annually to WFM when the vaccine becomes available.

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C

Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES

CONFIDENTIAL
COUNTY WORKFORCE MEMBER
GENERAL PRE-PLACEMENT MEDICAL HISTORY QUESTIONNAIRE

General Instructions below

Please complete this questionnaire in PEN and present to the staff at the examination clinic. To protect your confidentiality, it should not be given or shown to anyone else. On the day of your appointment, you must bring a valid driver's license or other form of identification which has both your photograph and signature.

LAST NAME:	**FIRST, MIDDLE NAME:**	**BIRTHDATE:**	**AGE:**	**EMPLOYEE NO.:**
ADDRESS:		**CITY:**	**STATE:**	**ZIP CODE:**
E-MAIL ADDRESS:	**HOME/CELL PHONE:**	**WORK FACILITY:**		**P/L:**
JOB CLASIFFICATION:	**ITEM NO.:**	**DEPT/DIVISION:**	**WORK AREA/UNIT:**	**WORK PHONE:**
OTHER NAME(S) USED INCLUDING MAIDEN NAME(S):	**LAST NAME:**	**FIRST, MIDDLE NAME:**		
IF YOU PREVIOUSLY HAVE HAD AN EXAM FOR LOS ANGELES COUNTY POSITION, PLEASE PROVIDE:				
POSITION:	**ITEM NO.:**	**DEPARTMENT:**	**DATE:**	

A response is required for each item below. Do not leave any blanks. Check "Yes" if you have had any of the following conditions in the last ten (10) years. Be sure to not omit conditions that were treated through the Los Angeles County worker's compensation system. You must explain all "Yes" and "Not Sure" answers on Page 5.

YES	NOT SURE	NO		YES	NOT SURE	NO	
			EYES, EARS,NOSE, THROAT				**GASTROINTESTINAL**
☐	☐	☐	1. Worn glasses/contact lenses	☐	☐	☐	23. Vomited blood
☐	☐	☐	2. Worn retainer lenses	☐	☐	☐	24. Persistent diarrhea
☐	☐	☐	3. Cataract	☐	☐	☐	25. Colitis
☐	☐	☐	4. Blurred or double vision	☐	☐	☐	26. Black/bloody bowel movement
☐	☐	☐	5. Glaucoma	☐	☐	☐	27. Recurrent hemorrhoids
☐	☐	☐	6. Blind spots	☐	☐	☐	28. Hepatitis
☐	☐	☐	7. Impaired peripheral vision	☐	☐	☐	29. Liver disease
☐	☐	☐	8. Refractive surgery/lasix	☐	☐	☐	30. Trouble swallowing
☐	☐	☐	9. Color vision impairment	☐	☐	☐	31. Pancreatitis
☐	☐	☐	10. Abnormal color vision test	☐	☐	☐	32. Hernia
☐	☐	☐	11. Sinus trouble	☐	☐	☐	33. Crohn's Disease
☐	☐	☐	12. Ruptured ear drum				
☐	☐	☐	13. Ringing/buzzing ears				**CARDIOVASCULAR**
☐	☐	☐	14. Hearing trouble	☐	☐	☐	34. Heart attack
☐	☐	☐	15. Abnormal hearing test	☐	☐	☐	35. Heart murmur
☐	☐	☐	16. Ear surgery	☐	☐	☐	36. Irregular heartbeat
☐	☐	☐	17. Ear aches	☐	☐	☐	37. Heart valve abnormality
				☐	☐	☐	38. Enlarged heart
			PULMONARY	☐	☐	☐	39. Chest pain or discomfort
☐	☐	☐	18. Asthma	☐	☐	☐	40. Heart failure
☐	☐	☐	19. Shortness of breath	☐	☐	☐	41. Swelling of feet/legs
☐	☐	☐	20. Chronic or frequent cough	☐	☐	☐	42. Leg pain while walking
☐	☐	☐	21. Chest tightness	☐	☐	☐	43. Painful varicose veins
☐	☐	☐	22. Wheezing	☐	☐	☐	44. High blood pressure

CONTINUE ON NEXT PAGE

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	EMPLOYEE NO.:

YES	NOT SURE	NO		YES	NOT SURE	NO	
			MUSCULO/SKELETAL				**MISCELLANEOUS**
☐	☐	☐	45. Fractures/broken bones	☐	☐	☐	73. Kidney disease
☐	☐	☐	46. Back trouble/pain/injury	☐	☐	☐	74. Bladder trouble
☐	☐	☐	47. Neck trouble/pain/injury	☐	☐	☐	75. Blood in urine
☐	☐	☐	48. Numbness of extremities	☐	☐	☐	76. Prostatitis
☐	☐	☐	49. Arthritis/Rheumatism	☐	☐	☐	77. Referred for psychological help
☐	☐	☐	50. Joint pain or swelling	☐	☐	☐	78. Mental hospitalization
☐	☐	☐	51. Shoulder injury/dislocation/pain	☐	☐	☐	79. Drug/alcohol treatment
☐	☐	☐	52. Elbow trouble/pain/injury	☐	☐	☐	80. Diabetes
☐	☐	☐	53. Wrist/hand trouble/injury/pain	☐	☐	☐	81. Thyroid trouble
☐	☐	☐	54. Hip trouble/pain/injury	☐	☐	☐	82. Anemia
☐	☐	☐	55. Knee trouble/pain/injury	☐	☐	☐	83. Enlarge glands
☐	☐	☐	56. Shin pain	☐	☐	☐	84. Skin problems/cancer/rashes
☐	☐	☐	57. Leg pain/injury	☐	☐	☐	85. Sun/heat intolerance
☐	☐	☐	58. Ankle/foot pain/injury	☐	☐	☐	86. Cyst/tumor
☐	☐	☐	59. Carpal Tunnel Syndrome	☐	☐	☐	87. Cancer/leukemia
				☐	☐	☐	88. Chronic fatigue
			CENTRAL NERVOUS SYSTEM	☐	☐	☐	89. Claustrophobia
☐	☐	☐	60. Epilepsy	☐	☐	☐	90. Multiple chemical sensitivity
☐	☐	☐	61. Convulsion/seizure	☐	☐	☐	91. Wool allergy
☐	☐	☐	62. Fainting spells	☐	☐	☐	92. Sleep Apnea
☐	☐	☐	63. Loss of consciousness	☐	☐	☐	93. Snoring
☐	☐	☐	64. Recurrent dizziness	☐	☐	☐	94. Trouble sleeping
☐	☐	☐	65. Head injury	☐	☐	☐	95. Low blood sugar
☐	☐	☐	66. Migraine headaches	☐	☐	☐	96. Blood clot in lungs/legs
☐	☐	☐	67. Frequent headaches	☐	☐	☐	97. Other condition that may affect job performance: _____ _____
☐	☐	☐	68. Stroke				
☐	☐	☐	69. Tremors				
☐	☐	☐	70. Traumatic Brain Injury				
☐	☐	☐	71. Chronic Neurological Disease	YES	NO	N/A	**FOR WOMEN ONLY**
☐	☐	☐	72. Attention Deficit Disorder	☐	☐	☐	98. Irregular vaginal bleeding
				☐	☐	☐	99. Menstrual problem that kept you from work

YES	NOT SURE	NO	
☐	☐	☐	100. Do you have any physical activity limitations?
☐	☐	☐	101. Do you need any special accommodations to assist you in performing any job tasks?
☐	☐	☐	102. Have you worked for the County of Los Angeles before?
☐	☐	☐	If "yes", at what position, and in which department? _____
☐	☐	☐	103. Have you been refused employment (including L.A. County positions) because of any physical, psychological, or medically related reason during the past 10 years?
☐	☐	☐	104. Have you been rejected for or discharged from a military position because of physical, psychological, or medically related reasons in the past 10 years?
☐	☐	☐	105. Have you failed a pre-placement medical or psychological exam in the past 10 years?

CONTINUE ON NEXT PAGE

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	EMPLOYEE NO.:

YES	NOT SURE	NO	
☐	☐	☐	106. Have you been terminated or resigned from employment due to a physical, psychological, or medically related reason in the past 10 years?
☐	☐	☐	107. Have you had a positive drug or alcohol test in the past 10 years?
☐	☐	☐	108. Have you been absent from work due to job stress anytime in the past 10 years?
☐	☐	☐	109. Do you occasionally use or are you currently taking any prescription or over the counter medications?
			If "Yes", please list name, dosage, frequency of use, and the reason the medication is used on Page 5.
☐	☐	☐	110. Do you currently have a cold/cough or have you had any in the last two weeks?
☐	☐	☐	111. Are you pregnant?
			If "Yes," what is your due date? _____
☐	☐	☐	112. Have you seen a doctor for back/neck pain, injury, or problems in the past 10 years?
☐	☐	☐	113. Have you been off work because of back/neck problems in the past 10 years?
☐	☐	☐	114. Have you had a recent change in the size or color of a mole, or a sore that would not heal?
☐	☐	☐	115. Have you missed more than five days from work due to medical reasons in the past year?
☐	☐	☐	116. Have you been exposed to loud noise?
			If "Yes", were you wearing ear protection? _____
☐	☐	☐	117. Do you have a commercial driver's license for driving trucks or buses?
☐	☐	☐	118. Are you a current cigarette, cigar or pipe smoker?
			A. How many cigarettes, cigars, or pipes do you smoke a day? _____
			B. How long have you been smoking? _____
☐	☐	☐	119. Are you an ex-smoker?
			A. How many years did you smoke? _____
			B. How many cigarettes, cigars, or pipes a day? _____
			C. When did you quit? _____
☐	☐	☐	120. Have you used chewing tobacco in the last 10 years?
☐	☐	☐	121. Has someone been concerned about your drinking or suggested that you cut down in the past 10 years?
☐	☐	☐	122. Have you been convicted of driving under the influence (DUI) in the last 10 years?
☐	☐	☐	123. Have you felt bad about your drinking at any time in the last 10 years?
☐	☐	☐	124. Have you had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye opener) in the last 10 years?

125. I am: ☐ Left handed ☐ Right handed
126. I drink _____ beers; _____ glasses/shots of hard liquor; _____ glasses of wine per week.
127. Describe any hobbies/recreational/work activities that have exposed you to noise, chemicals, or dusty conditions:

_____

128. Please describe your typical exercise or physical activity including any physical activity at work:

ACTIVITY	HOW MANY HOURS DO YOU SPEND DOING THIS PER WEEK?	HOW MANY MONTH/YEARS HAVE YOU BEEN DOING THIS ACTIVITY?
#1		
#2		
#3		
#4		
#5		
#6		

CONTINUE ON NEXT PAGE

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	EMPLOYEE NO.:

129. Please describe your current job and all jobs held in the last five (5) years (including military service):

JOB TITLE:	PRIMARY DUTIES:	EMPLOYER:	APPROXIMATE DATES OF EMPLOYMENT
			TO
			TO
			TO
			TO
			TO

YES	NOT SURE	NO	
			TUBERCULOSIS (TB) HISTORY
☐	☐	☐	130. Do you have history of a negative TB skin test?
☐	☐	☐	131. Do you have documentation of your negative test in millimeters from the last 12 months?
☐	☐	☐	132. Do you have a history of a positive TB skin test?
☐	☐	☐	133. Do you have documentation of your positive skin test in millimeters?
☐	☐	☐	134. Do you have documentation of a chest X-ray within the last 12 months?
☐	☐	☐	135. Have you received treatment for TB (INH) or other regimen?
			If "yes", how many months?_____
☐	☐	☐	136. Do you have treatment documentation?
☐	☐	☐	137. Have you ever been diagnosed as having active or infectious TB?
☐	☐	☐	138. Have you received a TB vaccine called BCG?
☐	☐	☐	139. Have you had a weakened immune system due to (check all that applies):
			☐ Chemotherapy ☐ HIV ☐ Organ transplant ☐ Leukemia ☐ Cancer ☐ Hodgkin's Disease ☐ Steroids (e.g., prednisone) ☐ Other:_____
			Note: Having immunodeficiency increases a person's risk for active TB infection/disease. If you think you may be immunocompromised, you should consult with your physician or licensed health care professional. DHS-EHS does not test for HIV or related diseases.
			TUBERCULOSIS (TB) SCREENING
☐	☐	☐	140. Do you have a cough lasting longer than 3 weeks?
☐	☐	☐	141. Do you cough up blood?
☐	☐	☐	142. Do you have unexplained or unintended weight loss?
☐	☐	☐	143. Do you have night sweats (not related to menopause)?
☐	☐	☐	144. Do you have a fever or chills?
☐	☐	☐	145. Do you have excessive sputum?
☐	☐	☐	146. Do you have excessive fatigue?
☐	☐	☐	147. Have you had recent close contact with a person with TB?

148. Please list any allergies with reactions to medication, food, or substances.

_____
_____
_____

CONTINUE ON NEXT PAGE

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	EMPLOYEE NO.:

149. Please list all medications including prescription, over the counter medication and herbal supplements.

_____
_____
_____

150. Please list all surgeries with approximate date(s).

_____
_____
_____

SUPPLEMENTAL INFORMATION

If you have answered "YES" OR "NOT SURE" to any questions, please provide detailed information below.

QUESTION NUMBER	
	(If Needed, Please Attach An Additional Sheet)

I hereby authorize the performance of a complete medical examination, x-rays, blood testing, and urine testing. I declare that my answers are true to the best of my knowledge and belief. I am aware that any willful inaccuracy may be regarded as cause for disqualification for employment, or dismissal after hire, or termination of assignment.

Type or Print Name of Workforce Member:	Complete Signature:	Date:

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. 29 C.F.R. Part 1635

CONTINUE ON NEXT PAGE

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	EMPLOYEE NO.:

EXAMINING HEALTHCARE PROVIDER'S HISTORY AND COMMENTS

(Please list Question # and Problem Name prior to each entry)

Physician or Licensed Health Care Professional Signature	Printed Name:	License No.:	Date:

Facility Name/Address:	Phone No.:

DHS-EHS OFFICE STAFF ONLY			
Completion of this form:	**Reviewed By (Print)**	**Signature**	**Date**

DHS-EHS staff shall verify/review documentation(s) and record completion of this form for workforce member. This form and its attachment(s), if any, such as health records shall be filed in workforce member's EHS health file. All workforce member EHS health records are confidential in accordance with federal, state and regulatory requirements.

DHS-EHS will obtain the workforce member's written authorization before using or disclosing medical information, include to self, unless the disclosure is required by State or Federal law such as to a public health authority or governmental regulatory agency.

Workforce members have the right to access their medical records and obtain a copy, thereof, within fifteen (15) days after the request.

K

Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES
DECLINATION FORM

FOR COUNTY DHS EMPLOYEE

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	EMPLOYEE NO.

JOB CLASSIFICATION	ITEM NO.	DHS FACILITY

DEPT/DIVISION	WORK AREA/UNIT	SHIFT	P/L

E-MAIL ADDRESS	WORK PHONE	CELL/PAGER NO	SUPERVISOR NAME

Please check in the section(s) as apply AND indicate reason for the declination.

I. ☐ 8 CCR §5199. Appendix C1 - Vaccination Declination Statement (Mandatory)

Check as apply: ☐ Measles ☐ Mumps ☐ Rubella ☐ Varicella ☐ Td/Tdap

I understand that due to my occupational exposure to aerosol transmissible diseases, I may be at risk of acquiring infection as indicated above. I have been given the opportunity to be vaccinated against this disease or pathogen at no charge to me. However, I decline the above vaccination(s) at this time. I understand that by declining the vaccine(s), I continue to be at risk of acquiring the above infection(s), a serious disease. If in the future I continue to have occupational exposure to aerosol transmissible diseases and want to be vaccinated, I can receive the vaccination(s) from DHS-Employee Health Services (EHS) at no charge to me.

Reason for declination: _____

_____

☐ Seasonal Influenza: I am aware that I will be required to wear a surgical mask whenever I have to work within 3 feet of a patient during influenza season.

Reason for declination *(check as apply):*

☐ I am allergic to vaccine components.
☐ I believe I can get the flu if I get the shot.
☐ I am concerned about vaccine side effects.
☐ It's against my personal belief.
☐ I don't believe I need it.
☐ I'm concerned about vaccine safety.
☐ I do not like needles.
☐ Other: _____

II. ☐ 8 CCR §5193. Appendix A-Hepatitis B Vaccine Declination (Mandatory)

☐ Hepatitis B

I understand that due to my occupational exposure to blood or other potentially infectious material (OPIM), I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to me. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational

PLEASE SIGN ON PAGE 2

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	EMPLOYEE NO.:

exposure to blood or OPIM and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series from DHS-EHS at no charge to me.

Reason for declination: _____

_____

III. ☐ Specialty Surveillance Declination (Mandatory)

Check as apply: ☐ Asbestos ☐ Hazardous/Anti-Neoplastic Drugs ☐ Other:_____

I understand that due to my occupational exposure as indicated above, I am eligible and have been given the opportunity to enroll in the Medical Surveillance Program. This will enable me to receive specific initial, periodic and exit medical examinations for the hazard identified above, at no charge to me and at a reasonable time and place.

However, I decline to be enrolled in this program at this time. I understand that by declining this enrollment, I will not be medically monitored for occupational exposure to this hazard. I understand that it is strongly recommended that I complete a medical questionnaire or examination. I also understand that if in the future I continue to have occupational exposure to the hazard identified above and I want to be enrolled in the Medical Surveillance Program, I can do so at any time at no charge to me.

Reason for declination: _____

_____

SIGN BELOW

By signing this, I am declining as indicated on this form.

EMPLOYEE SIGNATURE		DATE
EHS STAFF (PRINT NAME)	SIGNATURE	DATE

P

Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES

CONFIDENTIAL
8 CCR SECTION 5199 – APPENDIX B
ATD RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

Questionnaire for N95 Respirator

GENERAL INFORMATION on last page

COMPLETE ONCE EVERY FOUR (4) YEARS OR AS NEEDED

This Appendix is Mandatory if the Employer chooses to use a Respirator Medical Evaluation Questionnaire other than the Questionnaire in Section 5144 Appendix C (Form O).

To the PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL: Answers to questions in Section 1, and to question 6 in Section 2 do not require a medical examination. Workforce member must be provided with a confidential means of contacting the health care professional who will review this questionnaire.

To the WORKFORCE MEMBER: Can you read and understand this questionnaire (check one): ☐ Yes ☐ No

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Please complete this questionnaire in PEN and present to the staff at the examination clinic. **To protect your confidentiality, it should not be given or shown to anyone else.** On the day of your appointment, you must bring a valid driver's license or other form of identification which has both your photograph and signature.

SECTION 1

The following information must be provided by every workforce member who has been selected to use any type of respirator.

PLEASE PRINT LEGIBLY

TODAY'S DATE:			
LAST NAME	FIRST, MIDDLE NAME	AGE	GENDER ☐ MALE ☐ FEMALE
HEIGHT FT IN	WEIGHT LBS	JOB CLASSIFICATION	ITEM NO.:
PHONE NUMBER	Best Time to reach you?	Has your employer told you how to contact the health care professional who will review this questionnaire? ☐ Yes ☐ No	

Check type of respirator you will use (you can check more than one category):
- ☐ N, R, Or P disposal respirator (filter-mask, non-cartridge type only)
- ☐ Other type (specify): _____

Have you worn a respirator? ☐ Yes ☐ No	If "yes", what type:

SECTION 2

Questions 1 through 6 below must be answered by every workforce member who has been selected to use any type of respirator (please check "YES", "NOT SURE" or "NO").

YES	NOT SURE	NO	
			1. Have you ever had the following conditions?
☐	☐	☐	a. Allergic reactions that interfere with your breathing?

CONTINUE ON NEXT PAGE

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	EMPLOYEE NO.:

YES	NOT SURE	NO	
			If "yes," what did you react to? _____
☐	☐	☐	b. Claustrophobia (fear of closed-in places)
☐	☐	☐	2. **Do you currently have any of the following symptoms of pulmonary or lung illness:**
☐	☐	☐	a Shortness of breath when walking fast on level ground or walking up a slight hill or incline
☐	☐	☐	b. Have to stop for breath when walking at your own pace on level ground
☐	☐	☐	c. Shortness of breath that interferes with your job
☐	☐	☐	d. Coughing that produces phlegm (thick sputum)
☐	☐	☐	e. Coughing up blood in the last month
☐	☐	☐	f. Wheezing that interferes with your job
☐	☐	☐	g. Chest pain when you breath deeply
☐	☐	☐	h. Any other symptoms that you think may be related to lung problems: _____
☐	☐	☐	3. **Do you currently have any of the following cardiovascular or heart symptoms?**
☐	☐	☐	a. Frequent pain or tightness in your chest
☐	☐	☐	b. Pain or tightness in your chest during physical activity
☐	☐	☐	c. Pain or tightness in your chest that interferes with your job
☐	☐	☐	d. Any other symptoms that you think may be related to heart problems: _____
☐	☐	☐	4. **Do you currently take medication for any of the following problems?**
☐	☐	☐	a. Breathing or lung problems
☐	☐	☐	b. Heart trouble
☐	☐	☐	c. Nose, throat or sinuses
☐	☐	☐	d. Are your problems under control with these medications?
☐	☐	☐	5. **If you've used a respirator, have you ever had any of the following problems while respirator is being used?** ***(If you've never used a respirator, check the following space and go to question 6).***
☐	☐	☐	a. Skin allergies or rashes
☐	☐	☐	b. Anxiety
☐	☐	☐	c. General weakness or fatigue
☐	☐	☐	d. Any other problem that interferes with your use of a respirator
☐	☐	☐	6. **Would you like to talk to the health care professional about your answers in this questionnaire?**

Workforce Member Signature	Date

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. 29 C.F.R. Part 1635

PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL TO COMPLETE NEXT PAGE

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	EMPLOYEE NO.:

FOR COMPLETION BY A PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL
PROVIDE A COPY OF THIS PAGE TO WORKFORCE MEMBER

Part 1: Fit Testing Recommendation – Based on Questionnaire

☐ Questionnaire above reviewed.
☐ Medical Approval to Receive Fit Test
1. ☐ Disposable Particulate Respirators (N-95)
2. ☐ Replaceable Disposable Particulate Respirator ☐ a. Half-Facepiece ☐ b. Full Facepiece
3. ☐ Powered Air Purifying Respirators (PAPRs) ☐ a. Tight Fitting
4. ☐ Self-Contained Breathing Apparatus (SCBA)

Recommended time period for next questionnaire: ☐ 4 years ☐ Other _____ with justification _____

Date Completed: _____ Next Due Date: _____

Any recommended limitations for respirator use on workforce member: _____

☐ The above workforce member has not been cleared to be fit tested for a respirator.
- ☐ Additional medical evaluation is needed. Physician or Licensed Health Care Professional to complete Part 2 below.
- ☐ Medically unable to use a respirator.

☐ Informed workforce member of the results of this examination.

Part 2: Additional Medical Evaluations ☐ NOT APPLICABLE

☐ Medical evaluation completed.
☐ Medical Approval to Receive Fit Test
1. ☐ Disposable Particulate Respirators (N-95)
2. ☐ Replaceable Disposable Particulate Respirator ☐ a. Half-Facepiece ☐ b. Full Facepiece
3. ☐ Powered Air Purifying Respirators (PAPRs) ☐ a. Tight Fitting
4. ☐ Self-Contained Breathing Apparatus (SCBA)

Recommended time period for next questionnaire: ☐ 4 years ☐ Other _____ with justification _____

Date Completed: _____ Next Due Date: _____

Any recommended limitations for respirator use on workforce member: _____

☐ Medically unable to use a respirator.

☐ Informed workforce member of the results of this examination.

Comments: _____

Physician or Licensed Health Care Professional Signature	Print Name	License No.	Date

Facility Name/Address	Phone No.

Workforce Member Signature	Date

CONTINUE ON NEXT PAGE

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	EMPLOYEE NO.:

DHS-EHS OFFICE STAFF ONLY			
Completion of this form:	Reviewed By (Print)	Signature	Date

GENERAL INFORMATION

THIS QUESTIONNAIRE IS TO BE REVIEWED BY A PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL.

8 CCR §5199

Medical evaluation: DHS-EHS or contract agency shall provide a medical evaluation, in accordance with 8 CCR §5144(e) of these orders, to determine the workforce member's (WFM) ability to use the respirator before the WFM is fit tested or required to use the respirator. For WFM who use respirators solely for compliance with subsections (g)(3)(A) and subsections (g)(3)(B), this alternate questionnaire may be used.

8 CCR §5144(e)

1. General. DHS-EHS or contract agency shall provide a medical evaluation to determine the WFM's ability to use a respirator, before the WFM is fit tested or required to use the respirator in the workplace. DHS-EHS may discontinue a WFM's medical evaluations when the WFM is no longer required to use a respirator.
2. Medical evaluation procedures.
   a. DHS-EHS or contract agency shall identify a physician or other licensed health care professional (PLHCP) to perform medical evaluations using a medical questionnaire or an initial medical examination that obtains the same information as the medical questionnaire.
   b. The medical evaluation shall obtain the information requested by this questionnaire in Sections 1 and 2, Part A.
3. Follow-up medical examination.
   a. DHS-EHS shall ensure that a follow-up medical examination is provided for a WFM who gives a **positive** response to any question among questions 1 through 8 in Section 2, Part A of this questionnaire or whose initial medical examination demonstrates the need for a follow-up medical examination.
   b. The follow-up medical examination shall include any medical tests, consultations, or diagnostic procedures that the PLHCP deems necessary to make a final determination.

DHS-EHS staff shall verify/review documentation(s) and record completion of this form for workforce member. This form and its attachment, if any, such as health records shall be filed in workforce member's EHS health file. All workforce member EHS health records are confidential in accordance with federal, state and regulatory requirements.

DHS-EHS will obtain the workforce member's written authorization before using or disclosing medical information, include to self, unless the disclosure is required by State or Federal law such as to a public health authority or governmental regulatory agency.

Workforce members have the right to access their medical records and obtain a copy, thereof, within fifteen (15) days after the request.

A copy of the respiratory protection regulation Title 8 CCR §5144 and §5199 can be found at http://www.dir.ca.gov/title8/5144.html and http://www.dir.ca.gov/Title8/5199.html

T4

Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES

NOTICE OF PRIVACY PRACTICES

FOR COUNTY DHS EMPLOYEE

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	EMPLOYEE NO.
JOB CLASSIFICATION	ITEM NO.	DHS FACILITY	
DEPT/DIVISION	WORK AREA/UNIT	SHIFT	P/L
E-MAIL ADDRESS	WORK PHONE	CELL/PAGER NO	SUPERVISOR NAME

Effective Date:_____

ACKNOWLEDGMENT OF RECEIPT

By signing this form, you acknowledge receipt of the Notice of Privacy Practices for Los Angeles County Department of Health Services (DHS). DHS Notice of Privacy Practices (the Notice) describes how your protected health information may be used and disclosed and how you can get access to this information. Please read the Notice carefully. The Notice of Privacy Practices is subject to change. Any change in the Notice will be posted on DHS website at www.dhs.lacounty.gov, or you may request a copy from our staff.

I acknowledge receipt of the Notice of Privacy Practices for Los Angeles County DHS.

COUNTY WORKFORCE MEMBER SIGNATURE:	**DATE:**

INABILITY TO OBTAIN ACKNOWLEDGMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgment, describe the good faith effort made to obtain the individual's acknowledgment, and the reason why the acknowledgement was not obtained:

Reasons why the acknowledgement was not obtained:

- ☐ County Workforce Member refused to sign
- ☐ Other reason or comments:

_____

_____

_____

EHS STAFF NAME (PRINT):	**SIGNATURE:**	**DATE:**